Health: Cornerstone of Social Development

WORLD SUMMIT FOR SOCIAL DEVELOPMENT

Copenhagen
Denmark
6-12 March 1995

Attacking Poverty

Building Solidarity

Creating Jobs

The Health Gap

When looking at overall global health trends, the good news is that health status has improved during the second half of this century. Life expectancy at birth increased by more than 20 years (i.e., from 41 to 62 years) in the less developed regions between 1950 and the early 1990s, and by 8 years (i.e., from 66 to 74 years) in the more developed regions over the same period. A major reason for this progress was the falling infant mortality rates during this period: from 179 to 70 per 1,000 children in less developed regions, and from 59 to 10 per 1,000 children in more developed regions.

Nevertheless, the gap between rich and poor remains an all but unbridgeable chasm. For example, average life expectancy is 12 years greater (74 years as compared to 62 years) in more developed areas, while seven times as many infants die in least developed areas. Moreover, estimates indicate that 40 times as many women die as a consequence of complications of pregnancy and childbirth in the less developed regions.

Furthermore, despite improved survival in all developing regions, the least developed countries' progress was sluggish. Whereas they were only 5 years behind less developed regions as a whole in life expectancy in 1950 (36 vs. 41 years), by the early 1990s the difference had doubled to over 10 years (51 vs. 62 years).

The infant mortality profile in the least developed regions actually worsened. From a level only 8 per cent higher than developing regions as a whole in 1950 (194 vs. 179 per 1,000), it rose to almost 60 per cent higher by 1990 (110 vs. 70 per 1,000).

In sub-Saharan Africa, home to the majority of least developed countries, it is estimated that, at the end of the 1980s, women died of maternal complications three times more often than in less developed regions as a whole, and nearly 150 times more often than in more developed regions.

These differences in mortality risk are highly dependent on the causes of death. At present, of the 50 million people who die each year worldwide, some 38 million live in less developed regions. In addition, in the less developed regions, ten times as many deaths—44 per cent of the total — are due to communicable diseases, as opposed to only 4.3 per cent in developed areas.

Recent years have seen a shift in disease trends towards noncommunicable diseases such as cancer, cardiovascular diseases and diabetes, resulting largely from changes in lifestyles, environmental changes and the ageing of populations, in both developed and developing countries. Yet, even for diseases that are greater killers in the more developed regions, their burden of death can be greater in the less developed regions. Although nearly half (48 per cent) of deaths in more developed regions are due to diseases of the circulatory system, in absolute numbers more people die from these diseases in the less developed regions.

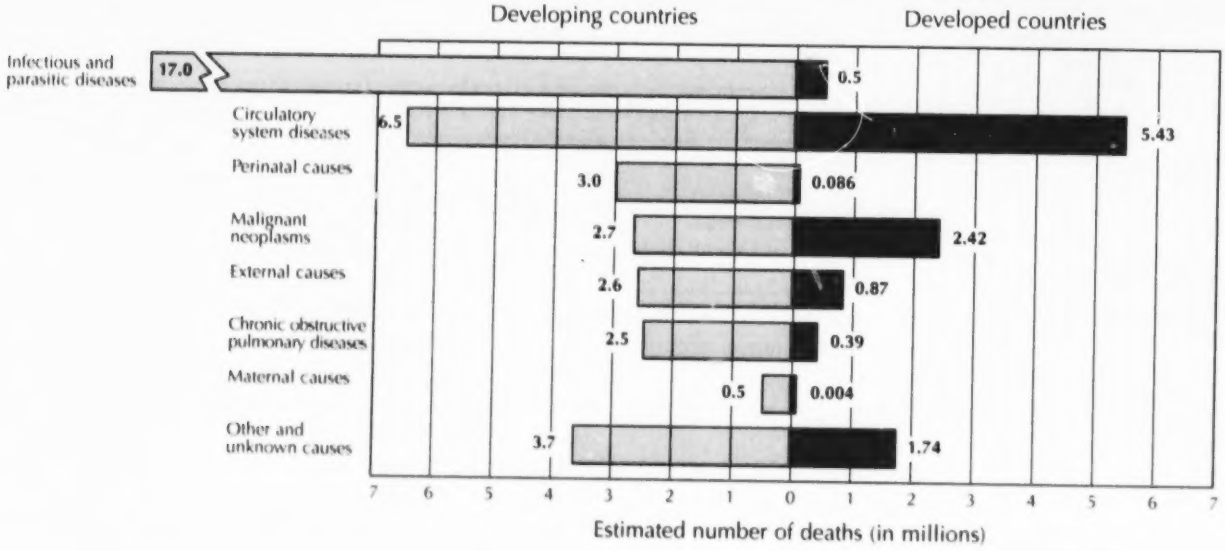
In addition to the relatively recent emergence of HIV/AIDS, there has been a resurgence of old scourges such as tuberculosis, malaria and cholera.

The health dimensions of today's complex social problems call for a multifaceted response that is not restricted to medical solutions. Strategies that address health problems will also need to relate them to the other major social problems of the 1990s.

Health status gaps between regions mirror the unequal development of health infrastructures that varies both by population group and by community within a given country. Affluent populations enjoy ongoing access to local health care services, while the populations of the least developed regions had far less (89 per cent as compared to 69 per cent coverage in 1991).

UNITED NATIONS

Estimated annual number of deaths, by cause, in developing and developed countries, 1990



Source: World Health Organization

Consequently, 11 per cent of the 4 billion people living in developing countries remain without access to important components of health care; a disproportionate 40 per cent of these are among the half billion people who live in the least developed regions.

Communities and social systems all over the world are disrupted by rapid and often poorly planned or poorly coordinated economic growth, some of which escalates into political strife or even full-scale war. It has become evident that economic growth alone is not sufficient to ensure the widest enjoyment of health and well-being.

Health is central to any agenda for social development

At the same time, according to the conclusions reached by the WHO-sponsored Expert Group Meeting on Health and Social Development (6-8 December 1993), it has become apparent that health is an integral component of social development, and the health sector has an undeniable capacity to enhance participation in the development process. Health is central to any agenda for social development.

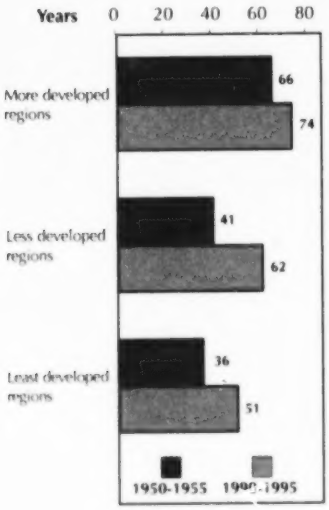
The Issues

Symptoms of the social crisis of the 1990s which also constitute the core issues of the Social Summit — poverty, unemployment and social integration — are reflected in the health status profiles presented above.

The World Health Organization (WHO) considers that health is both a goal and a means of achieving social development. Health is inseparable from economic and social productivity and family cohesiveness. Equity in access to health services, therefore, is an essential component of strategies for social development. This outlook is fundamental in addressing each of the three core themes of the World Summit for Social Development — the reduction and elimination of poverty, productive employment and the reduction of unemployment, and social integration.

WHO is working with a growing number of countries to define health reform policies that take into consideration the complex interaction of factors at play in an evolving political and economic environment. This work is being conducted by WHO in close collaboration with the United Nations system, financial institutions and other development partners. The health and well-being of people, particularly the poor and the marginalized, is the main target of such policies, aiming, in the long term, at self-reliance and sustainable development. This collaboration, implemented within the framework of the WHO policy for intensified cooperation with countries and peoples in greatest need, deals with many of the issues involved in the three core themes of the Summit.

Life expectancy at birth by development level, 1950s and 1990s



Source: World Health Organization

WHO's Constitution defines health as "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity". The attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead socially and economically productive lives was defined as a main social target by the World Health Assembly in 1977. This goal is to be attained through the implementation of a primary-health-care policy based on equity and social justice and the firm belief that health is a fundamental human right and a world-wide social goal.

Future Priorities

WHO has established four interrelated policy orientations as the foci for action by the international health community. These orientations provide the framework for WHO's work during the period 1996-2001.

1. Integrating health and human development in public policies: WHO's primary responsibility is to examine how the existing development strategies and policies of countries can be strengthened to protect and improve the health status of their people and bring health objectives into the centre of current development strategies. Health must become an integral part of the political, social and economic issues which are emerging as the current major priorities of development policy makers.

2. Ensuring equitable access to health services: Equity of access to care, with special reference to the poor and marginalized, is basic to development strategies aiming at social justice. WHO strives to bring Governments to reconfirm their commitment to equity through appropriate health financing policies, including health insurance, and the control of overall levels of health expenditure. This commitment is directed especially towards those populations who have least access to health care—such as the rural and urban poor, the unemployed, women, children, youth, the elderly, migrants and refugees.

3. Promoting and protecting health: According to WHO, individuals, families and communities should actively participate in their own health development. This means adopting healthy lifestyles and improving nutritional status, living conditions and environment. Protecting the health of minorities, the underprivileged and high-risk population groups, including nomads and indigenous peoples, is an important challenge, to be met through the application of integrated approaches that increase both the capacity of individuals to be self-sufficient and the capacity of services to respond to their changing needs.

4. Preventing and controlling specific health problems: Primary health care and programmes for the control and elimination of diseases are essential components in the fight against poverty and social exclusion. The health and well-being of people, particularly the poor and marginalized, should be the main target of policies aiming at self-reliance and sustainable development. WHO's role in this connection is to stimulate authorities to develop national policies addressing specific health problems and to implement integrated measures for disease prevention and control.

For further reading:

Action for Public Health Sundsvall Statement on Supportive Environments for Health, June 1991.

A Call for Action — Promoting Health in Developing Countries (Summary Report of the Working Group on Health Promotion in Developing Countries), October 1989.

Alma Ata Reaffirmed at Riga — From Alma Ata to the Year 2000: A Midpoint Perspective, March 1988.

Implementation of the Global Strategy for Health For All By The Year 2000; Second Evaluation — 8th Report of the World Health Situation. WHO, 1993.

Ninth General Programme of Work (covering the period 1996-2001). Document of the 47th World Health Assembly, 1994.

Statements of Dr. Hiroshi Nakajima, Director-General, WHO, to the Executive Board and the World Health Assembly. WHO, 1994. A47/DIV/4.

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DPI/1493/SOC/CON — 94-35789— September 1994 — 30M